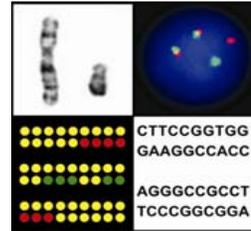


# UW Cytogenetic Services

Wisconsin State Laboratory of Hygiene  
University of Wisconsin-Madison  
465 Henry Mall, Rm 419, Madison, WI 53706  
Phone: 608.262.0402 Fax: 608.265.7818



## Request for Release of DNA Sample

Date of request (mm/dd/yyyy): \_\_\_\_\_

Depositor Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip code: \_\_\_\_\_

**Requested DNA amount in micrograms:** \_\_\_\_\_

Please send the above amount of DNA from my banked DNA samples to the following testing facility or medical professional at the following address:

**Testing facility or medical professional:** \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

Facility paperwork included

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I authorize the release of a sample of DNA from \_\_\_\_\_, (the depositor), to the above mentioned diagnostic laboratory or medical professional and understand the implications of the DNA testing to be completed.

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**(signature of depositor or subsequent owner of DNA)**

*To be completed by a physician or genetic counselor:*

I have explained the DNA testing to be completed at the diagnostic facility specified above to the depositor and/or his/her legal guardian or owner of the banked DNA sample and have answered all this individual's questions.

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Print name

Signature

Date

Address: \_\_\_\_\_